The difference in this respect is not considered of very great value for diagnosis, the less so since variability rather than high pressure is the characteristic of the psychoneurotic. The author gives his conclusions as follows: (1) The average blood pressure in paresis, taken as a whole, is high. (2) This is doubtless due to the prevalence of atheroma with its cardiac and renal accompaniments. (3) The average blood pressure in cases of paresis without atheroma, cardiac enlargement or renal disorder, is probably somewhat lower than that of health, but the variations are so great that it can not be said to be uniformly low. (4) The test is not likely to prove of great practical value in the differentiation of paresis from other nervous disorders, though here, as elsewhere, it is of great value in estimating the circulatory condition of the individual. (5) These observations are too few to establish a rule with regard to the blood pressure in varying emotional states. So far as they go, however, they tend to show that: (a) The excited states of paresis are as likely to be accompanied by high as by low pressure; (b) mental depression is accompanied by high oftener than low pressure, but that it is not incompatible with low pressure; (c) while the average pressure in euphoria is perhaps somewhat lower than in the other mental states of the general paralytic, it is not inconsistent with high pressure or with pronounced atheroma with its cardiac and renal accompaniments.

PROGNOSIS OF MULTIPLE SCLEROSIS. O. Maas (Berl. klin. Woch., 44, 7, 1907).

The author makes an interesting communication based on the history of a patient from Oppenheim's Poliklinik. A 58-year-old woman had had for eighteen years a typical case of multiple sclerosis, which developed slowly and progressively. The process then came to a standstill. She became very much better, and although showing unmistakable signs of disturbance of the nervous system she has been in this improved condition for thirteen years. JELLIFFE.

THE PRESENT STATUS OF BRAIN SURGERY. M. A. Starr (Journal A. M. A., Sept. 22).

The author considers that sufficient time has elapsed to enable us to estimate the value of brain surgery for the relief of tumors, epilepsy and abscess with considerable accuracy. It is only in localized Jacksonian epilepsy (about 2 per cent. of all cases), that operation is indicated and in only about 20 per cent. of these is it successful. Trephining for epilepsy, therefore, is of very limited application and is only to be recommended in a few selected cases which present the necessary guide to both physician and surgeon. In abscess of the brain, early operation as soon as the condition is diagnosed is imperative, and in cases of skull fracture or concussion followed within two or three weeks by symptoms suggestive of abscess, even if there are no localizing symptoms, trephining is imperative. There are many regions of the brain, injuries of which are associated with no localizing signs. In abscess due to chronic otitis, operation is demanded as soon as the diagnosis is made. While statistics show the percentage of recoveries after operation for cerebral abscess at present is only about 60 per cent., there is every reason to believe that it will be much greater when early diagnosis and immediate operation is the rule. In brain tumor with positive localizing symptoms, operative interference may be warranted, but in the far greater number, without localizing symptoms, operation promises nothing. Post-mortem statistics indicate that about 10 per cent. of brain tumors are open to surgical treatment, and that the best results may be expected when the growth is located near the Rolandic or Sylvian fissures, and the highest mortality when it is in the cerebellum. The proposition to afford relief in inaccessible tumors by making a considerable opening in the skull to relieve pressure, may be of value in some cases. Starr mentions one of his own observations in which this procedure was of benefit and two others in which it failed. In cases of extradural hemorrhage from traumatism, with symptoms of intracranial pressure, slow pulse, steady rise in blood pressure, deepening coma, Cheyne-Stokes respiration, and increasing hemiplegia, all appearing within six hours of the injury, trephining is sufficiently clearly indicated. The hemorrhage is usually from the middle meningeal artery, hence a large trephine opening or a large, bony flap should be made in the area just above the ear. In apoplexy Cushing has applied successfully, in hospital cases, the test of the condition of the blood tension in determining the need of surgical intervention to save life. When the blood pressure rises steadily to 250 mm., measured by the Riva-Rocci or the Janeway apparatus, in a case of apoplexy, and when coincidentally with this there is a slow pulse falling to 50 a minute it may be said that the case will be fatal unless pressure is relieved by a considerable opening in the skull, without regard to the finding or removal of the clot. The best place for this is over the motor area of the side opposite the paralysis, as the clot may be there. Cushing's cases show that this operation may sometimes save life in an otherwise hopeless condition. Cushing has also treated surgically with success newborn infants who, after a difficult labor, have suffered an extradural or intradural hemorrhage. Such infants usually die, or if they survive are defective, hemiplegic, idiotic, etc., and any measure for their relief is justifiable. It is easy in these cases to relieve intracranial pressure by opening the sutures of the parietal bone with scissors, and his success warrants urging obstetricians to consider this operation in the case of asphyxiated infants of the class described above. Obstetricians see these cases, and if they are convinced that delays are dangerous the percentage, Starr says, of idiocy and hemiplegic epilepsy will certainly be reduced. The last class of cases of cerebral hemorrhage suitable for trephining is that in which hemiplegia or hemianopsia develops slowly after an injury and does not come to its height for three or four days. In these there is probably a surface hemorrhage from a vein in the pia mater and lumbar puncture will probably reveal blood in the cerebrospinal fluid. The symptoms may progress and threaten life, or come to a standstill, leaving the patient permanently incapacitated. In either case surgery is indicated. Starr refers here to a case of this kind in which a clot was removed from the lower third of the Rolandic fissure with good results, and remarks that many other similar cases, equally successful, could be cited. In conclusion he refers to the methods that have been recommended and employed to cure microcephalic idiocy by relieving pressure on the brain and permitting its expansion. Experience has shown the uselessness of such surgery, and it is no longer recommended.